

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Township

or

Village

or

City *St. Louis* (NO. *City Hospital 28* Ward)

Registration District No. *791*

File No. -

4061

Primary Registration District No. *1003*

Registered No.

697

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *James McLean*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDDED OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH *June 3 1850*
(Month) (Day) (Year)

7 AGE *65* yrs. *7* mos. *6* ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Labourer*
(b) General nature of industry business or establishment in which employed (or employer) *Day*

9 BIRTHPLACE (City or town, State or foreign country) *St. Louis*

10 NAME OF FATHER *Robert McLean*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Virginia*
12 MAIDEN NAME OF MOTHER *Mary Handling*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Virginia*

14 THE ABOVE-~~SEE TO THE BEST OF YOUR KNOWLEDGE~~ *St. Joseph's Hospital*
(Informant) *Ernan*
(Address) *City Hospital*

15 Filed *maulo starkloff* 191*6* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 9 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *June 7 1916* to *June 9 1916*, that I last saw him alive on *June 8 1916*, and that death occurred, on the date stated above, at *547 A.*

The CAUSE OF DEATH* was as follows:
Labar Pneumonia

CONTRIBUTORY (Secondary) *aw*
(Duration) *aw* yrs. mos. ds.
(Signed) *D. W. Kippel* M. D.
June 9 1916 (Address) *City Hospital*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos. *7* ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?

Former or usual residence *5565 E. Etzelp*

19 PLACE OF BURIAL OR REMOVAL *Wesleyan Cem.* DATE OF BURIAL *Jan 18 1916*

20 UNDERTAKER *Wagoner* ADDRESS *36th St. St. Louis*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

